The STANDARD INSURANCE

State of Arizona
Long Term Disability Claim
Employer Statement

Reset

Standard Insurance Company, Employee Benefits Department
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel 800.378.6053 Fax

TO BE COMPLETED BY EMPLOYER

1. Employee's Full Name:	Social Security No.:	Job Title: *(Please attach a copy of the job description.)*	Date Employed:
Employee Address:		Telephone No.:	

2. Long Term Disability
In which of the following retirement plans or programs does the employee participate?
- ☐ Public Safety Officers Retirement Plan
- ☐ Elected Officials' Retirement Plan
- ☐ Correctional Service Officers Retirement Plan
- ☐ Optional Retirement Plans of the universities (AIG, VALIC, Aetna, Fidelity, TIAA-CREF and Vanguard)
- ☐ A Judge Pro Tempore, an employee in a medical residency program or a Cooperative Extension employee on federal appointment who by statute is not entitled to pension and isn't on per diem basis who is actively at work 20+ hrs/wk.

If the employee is a member of ASRS, The Standard is not their Long Term Disability carrier. Please contact ASRS to initiate a Long Term Disability claim.

3. Amount of Basic Life Insurance (Plan 1) with The Standard $_____ ☐ Class 1 ☐ Class 2

Amount of Voluntary Life Insurance (Plan 2) with The Standard $_____

Non-Smoker Benefit ☐ Yes ☐ No

Does employee have life insurance for dependents under the group policy? ☐ Yes ☐ No

Does employee have life insurance for spouse under the group policy? ☐ Yes ☐ No

If yes, amount of Life Insurance: ☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $12,000 ☐ $15,000

PLEASE CONTINUE PAYMENT OF PREMIUMS UNTIL OTHERWISE NOTIFIED UNLESS EMPLOYEE HAS BEEN TERMINATED.

4. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

Name of Workers' Compensation Carrier: _____

Has employee applied for benefits? ☐ Yes ☐ No Is employee receiving benefits? ☐ Yes ☐ No

5. Employee's earnings: $_____
(Check one) ☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ other

Date of last increase: _____ Earnings prior to increase: $_____

Yearly employment schedule, indicate:
☐ 12-month period ☐ Other *(i.e. contract days, 9 mos., etc.):* _____

6. Last active day at work:

7. Job status when disability began: ☐ Full-time (____ hours/week) ☐ Part-time (____ hours/week)

8. Date employee returned to work: _____

9. Is employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No
If subject to Social Security taxes what are the employee's year to date Social Security wages?

10. Have you considered allowing the employee to work in another occupation, or to modify and/or alter the job duties of the current occupation?

☐ Yes ☐ No Please explain: _____

On FMLA? ☐ Yes ☐ No Effective date: _____ through: _____

11. Is employment scheduled for termination? ☐ Yes ☐ No Effective: _____

Reason: ☐ Unable to hold job open any longer ☐ Elimination of position ☐ Retirement ☐ For cause ☐ Other: _____
(this information is needed to assist in return to work services)

12. Date sick leave benefits will be paid through: _____ Salary continuation from: _____ through: _____

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DEDUCTIBLE INCOME

13. Is employee covered by or now receiving benefits from the following?	Covered Yes	Covered No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Sick Leave/Donated Leave	☐	☐	☐	☐	☐				
b. Social Security	☐	☐	☐	☐	☐				
c. Workers' Compensation	☐	☐	☐	☐	☐				
d. Retirement or Pension (Employer, ASRS, etc.) Please specify: _____	☐	☐	☐	☐	☐				
e. Other: _____ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

ATTACHMENTS

Please attach copies of the following.

a. Job Description
b. Employment Application or Resume
c. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, Retirement System)
d. Enrollment Form
e. Original Beneficiary designations and subsequent changes

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: State of Arizona – 617950 Agency Name: _____ Location Code: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice below.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

Phone No.: (_____) _____ Fax No.: (_____) _____

CLAIM FORM FRAUD NOTICE

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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